

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

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9:00 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

Agenda item:

Complexity of the Medicare program and regulatory burden

David Glass, Marian Lowe, Anne Mutti, Helaine Fingold

P R O C E E D I N G S

MR. HACKBARTH: Good morning, everybody. Welcome. The first item on our agenda this morning is the complexity of the Medicare program and regulatory burden. David?

MR. GLASS: Today we'd like to get the Commission's reaction to the draft report, which is in your binder there at tab K, and see if we can get agreement on the approach in there. And also, look at the draft recommendations, if we have time.

This report stems from the Congressional tasking in the BBRA and asked us to look at the complexity of the Medicare program and the level of burden placed on providers to federal regulation. The report is due by the end of December, so that means next meeting we'll have to have a final draft and get the commissioner's input, put in changes, and prepare for December publication. So it's a fairly tight schedule.

Our approach to this was to listen to the providers and CMS and beneficiaries, collected some testimony on the panel that we didn't quite have in September, and also comments on the Federal Register notice at that time. We conducted some site visits, literature search, that sort of thing, to try and understand what the problem was.

After doing that, we decided that we weren't going to attempt to catalogue regulations and their burden or create top 10 lists of the most annoying regulations. The reason for that is that's really already being done by every professional society. They each have their top 10 list of regulations they'd like to see changed or eliminated. The things that are well known, CMS and Congress know about them already and they may already be working on solutions. The Physician's Regulatory Issues Team, for example, in CMS is working on a lot of the regulations that are bothering providers.

So we didn't want to duplicate that. Instead, we thought it would be a good idea to go back to the source of the burden, which is really the complexity of the Medicare program, and see if something could be done at that end. I like to use a gardening analogy. If you're going to prune the tree, you can cut off the branches that stick out and poke you every time you walk down the path. That's kind of the let's get the top 10 out of the way approach.

Another approach is to look at the shape of the tree and decide is there some major branch that could be taken out of it that would improve the health of the tree and eliminate a lot of branches and small branches and things that are bothering you. We're trying to take the latter approach.

So what do we know about complexity? Understand the sources of complexity in the Medicare program, what we decided to do was to understand which of those stem from how the program started, because there are certain odd aspects of the program that are split between Part A and Part B and the use of local contractors,

that sort of thing, that were there at the very start of the program. And that can be the source of complexity now. Other sources could be increasing size and scope of the program over the years and differing goals.

So we want to understand each of those and try to understand what are the sources of complexity now and then try to sort out what we call irreducible complexity. There are certain aspects of the program that you're just going to have to have in the program. Some of that exists because of the size and scope of the program. If you have beneficiaries in all 50 states plus a couple of territories and Puerto Rico and such, that's just going to make for a complex program in itself. You have a lot of them, and you have a lot of providers. So there's a certain amount of complexity that you're probably not going to be able to avoid, and I would call that irreducible.

You have other aspects such as beneficiary protection and fiscal prudence, I mean you'd have a very simple program and write a check to each provider at the beginning of the year, but that wouldn't be very prudent and you can't go that far.

So the idea then is to sort out the irreducible complexity, figure out what can be simplified, link complexity to burden, identify what could be simplified, and if you can do that you could then identify promising targets for simplification which would, in turn, reduce burden. So that's our general approach to complexity.

So what are some of the promising targets that we've come up with? The first is kind of the excessive layers of the administration, and within that the contractor role and levels of enforcement. What we're talking about here is the program tends to get bogged down in multiple layers of issuances, regulations, carrier manuals, provider bulletins, all of which people eventually try to understand the program from. Each does the same thing slightly differently and that can lead to misunderstanding and inconsistencies.

That problem, that layer problem, is multiplied by having many contractors, each communicating in its own way, to the providers and beneficiaries. It becomes exponentially worse when you have multiple automated systems involved in the claims processing and other aspects of the program. The software changes made prior to final regulations, for example, may get implemented differently than would have been expected. That can lead to problems where the claims processor is using their software to deny claims or to, even worse, pay claims and then the IG comes in later and says oh, that's not the way the regulation should have been interpreted. And the provider is the one who ends up with the problem.

We said why do things this way? It's an example really of the complexity because of the way the program started. When you were paying on the basis of local uniform, customary and reasonable charges and cost audits, it may have made sense to use local insurance companies to pay the claims, and that was also something that appealed to the legislators because that would seem to be the least threatening, the thing that providers were used to have happening, and it kind of kept the federal

government out of the program.

So using many local contractors and having the Part A and Part B split all might have made sense at one point. But the question is why continue it now? It doesn't make sense if you have nationwide prospective payment systems to continue with this claims processing system that was designed for uniform, customary and reasonable charges and costs.

We consider this an example of the way the program started leading to complexity that now could be simplified. So that's what we mean by the contractor role.

We think that if you rethink the contractor role, and it particularly makes sense because there are also now nationwide chains of providers. So if you want to rethink the contractor role completely, you can probably change the division of labor between the government and contractors and perhaps between all the different forms of contractors we have now. We have carriers and fiscal intermediaries and RHHIs and DMRGs and we have program safeguard contractors. It's not clear that you want all those divisions and boundaries.

So if you rethink that division of labor, you could probably also get rid of local medical review policy, which would be a tremendous simplification. And I think we heard some of that yesterday, people saying that it's making things very complicated for providers. We'll get to recommendations in a minute.

The other question is the levels of enforcement, as far as excessive layers of administration go. This is kind of complexity because of the changes in the program probably. The new emphasis in funding from HIPAA suddenly invented these program safeguard contractors and made a lot more money available. It also gave more money to the HHS Office of Inspector General. And now we have the OIG, the Department of Justice, program safeguard contractors, a lot of people involved in the enforcement question and this is looked upon as a tremendous burden by providers. People are extremely scared and worried by the system, sure that no matter what they do, even if they follow every rule, someone's going to tell them oh, you were wrong, that wasn't one of the rules you were supposed to follow, and they'll be in trouble.

That seems to be really pervasive here. We think a lot of that might stem from the fact that there's so many levels of enforcement now and that there could be better coordination between them. We'll have a recommendation on that, as well.

Regulation proliferation, obviously if you're worried about having too many regulations you either have to get rid of some of the ones you have or prevent new ones from being created. We think that here the pace of changes is a large part of the problem. So many new laws are passed which then require new regulations to enforce them, it becomes very difficult for people to keep up with the changes.

We think, in this case, that -- as we'll get into in the recommendations -- that Congress could give CMS more flexibility on schedules and allow them to test regulations out. And if that could be done, that might create less need for correcting laws and regulations when the first one didn't work out quite as

intended. This new payment system may be an example of that.

We also think it may be a possibility of having some kind of sunset mechanism to get rid of some of the regulations that current exist. One way of doing that is say everything that's over a certain number of years old you get rid of or you re-examine. But we think it may be better to approach it by saying as you change the program have a mechanism so that you can search out things that may no longer be needed.

Examples of this may be the adjusted community rate proposal in the M+C world, which was originally designed to adjust commercial membership cost to Medicare membership costs, but now you don't need to have commercial members anymore. So the whole logic of that seems to say well, why have that?

Cost reports are another example. If we use cost reports for payment, they probably are more complex and detailed than the cost reports we may need to do, the sort of things you were talking about yesterday for updates, and looking at whether the payment is adequate. So we tried to eliminate some regulations in that way.

And finally, technology would seem to have some real benefits. The provider interface -- and by that we mean as the providers interact with the program what do they see? What kind of forms do they have to send in? What do they get back?

Even if you can't simplify some of the payment systems, you could conceivably greatly simplify the interface with the providers so before they were sent in a claim they would be able to tell whether it would pass the preliminary edits. Does it have all the correct information and that sort of thing.

I looked kind of at tax software. Some of us do our own income taxes and we use tax software programs. It's a very complex tax system but all you have to do is put in a certain amount of data and the software does all the work for you. It understands all of the complexity. So if we could try to simplify the interface with the providers, something like that perhaps might be possible.

Better communication, we think also, if you could use technology to improve your communication by having one website that would perhaps have the answers you wanted, and there would be one of them and everyone would get the same answer, that would probably be a tremendous benefit for the system. But that would probably require more resources for the CMS to do any of that technology work.

I think, if you'd like to discuss now, we can do so or we can go to recommendations.

MR. HACKBARTH: Why don't you go ahead and do the recommendations.

MR. GLASS: This relates to this question of rethinking the contractor role and getting rid of some unnecessary layers in the system. You can see that the idea would be to have a standard nationwide system which, if you were inventing the program from scratch now, you would probably say well, of course, what else would you do? Why would you have 100 different systems out there if you're going to provide the same benefit to beneficiaries across the country?

So we're saying okay, move to a nationwide system. It would require that Congress allow CMS to eliminate local medical review policies and local descriptions of policies and regulations. And then you'd also allow CMS to contract as necessary to do this.

DR. NELSON: May I ask a question at this point to clarify? I presume that there could still be a role for carrier advisory committees at the local area, even though there would be a same set of rules. There still could be a role for advisory committees in terms of interpretation or the way information is disseminated to assist in particular local circumstances and things of that sort? Or did you see that there would no longer be a need for carrier advisory committees?

MR. GLASS: No, I think you could still have them. Many carriers now cover multiple states and there are still carrier advisory committees around. So I would think that you could still have that mechanism to communicate to the system. It's just the system you'd be communicating to wouldn't be oriented on local carriers, per se.

MR. HACKBARTH: It would be helpful to me if we could get all of the recommendations out. I'm trying to see the big picture, the big framework. And then we can come back and ask detailed questions about either the framework or specific recommendations. David, why don't you move through the recommendations as quickly as you can?

MR. GLASS: We can zip through them pretty quickly then.

Recommendation two, following on recommendation one, if you could develop a nationwide system that could then be clearly communicated to providers, we would hope it would be possible to carry out this recommendation which is that providers should not be subject to penalties for relying on official guidance from the Medicare program that is later found to be error.

This is a tremendous complaint from providers, that they can actually call up, do what they're told, and get punished anyway later. It seems ridiculous to them, and it does seem kind of ridiculous to us, as well. This would raise other issues such as what constitutes official guidance and who would be considered capable of providing it, and that sort of thing.

But if you had one standard system it would be much easier to explain to people what the rules were. And we think then you could probably follow up with this, and this would relieve I think a tremendous source of -- if not burden, at least uncertainty and apprehension from the provider community.

If you have no local contractors, then you can probably rethink the proper function of the CMS regional offices, inasmuch as they're involved with contractor supervision and management. We think there are certain other things that might happen to the program that would make this appropriate. For instance, if you start putting Medicare people in local Social Security Administration offices and that sort of thing. You may need to rethink the role of the regional offices and figure out how they would mesh with that. So we think that the current role may well have to change and this should be rethought.

In the paper we gave you, we brought up these questions of balance, of how in regulatory systems you have choices about how

you might want to do things. We think it might be appropriate to evaluate whether the Medicare program has a correct balance between up front vetting of providers. That is, are you very careful who you let in your network and review them carefully up front? Or back end rigor of claims processing enforcement.

Here we think the balance is probably too much toward the back end side now. We're going to let in everyone and then we're going to check everything everyone does every carefully.

DME is kind of an example of this. They actually started requiring that DME suppliers provide Social Security numbers and an actual address. That seems pretty reasonable, but that was considered changing the balance to more up front vetting of providers. So we think that sort of thinking could probably be applied in other areas, as well.

Recommendation five. This is interesting, what can they do? We would call them to try to rationalize enforcement roles and activity, the idea being that providers feel that they're subject to multiple audits and investigations from all these different agencies involved. If the current structure is appropriate, it would be nice to be able to explain to people why and how it's beneficial. And if not, we think it probably should be rethought and perhaps rationalized in some way.

We think that also might lend itself to making better use of audit and investigation results, so you don't have to have multiple audits and that sort of thing.

This recommendation speaks to trying to slow the pace of adding additional regulations. We're trying to do that by avoiding corrective actions, where Congress passes a law, it's put into regulation, things start happening, they don't like the result and have to pass another law to correct it. We think that some of that could be avoided with more reasonable timelines on setting up, for example, new prospective payment system and providing more resources for CMS to develop and test the regulations thoroughly before implementation.

We'd also, of course, like the people who are doing the testing to be independent of those perhaps proposing the system, to make sure it's a good test. Again, the idea here is we're trying to prevent the constant phenomenon of a law being passed, people not liking the result when it finally happens, and then having additional series of laws and regulations.

This is at the other end of the regulation life cycle, where we'd like to be able to eliminate regulations that become obsolete as a result of program changes. Again here, the adjusted community rate proposals in the M+C world and some of the perhaps the cost reports on the fee-for-service side are examples of this.

This is kind of our catch-all technology recommendation, that CMS has probably dropped many years behind the power curve on this. Again, tied to the first recommendation, in that if you simplified the system and have a standard system, this becomes much more a practical thing to do.

Right now you can go into a gas station and flick your card through the thing and it communicates by satellite, approves your card by the time you put the gas nozzle into your tank. But for

a provider to determine whether a beneficiary is really covered by Medicare they have to consult the common working file, which doesn't work 24 hours a day, isn't available necessarily all the time, and is three or four weeks behind. It doesn't seem possible that that has to be that way.

So we think if we simplified the program to begin with, go to a standard system, that would allow technology to be used in a much more appropriate and up-to-date manner and relieve a lot of the burden providers feel.

That's what we've got.

MR. HACKBARTH: Thanks, David. Just a word about the draft recommendations, in particular for the people in the audience. This is the first time that the commissioners have seen these, and the purposes of the draft recommendations at this point is to stimulate thinking and discussion. So what we finally agree on may or may not have any similarity to these draft recommendations.

MS. NEWPORT: David, first a context question. The so-called RACER bill was just passed or it will be passed by the House fairly soon, which is an attempt to get at some of the issues with the fiscal intermediary structure. Yesterday Bob Berenson spoke to us about he thought that would make it even more complex.

I guess in the context of this discussion and this chapter, I think we need to be aware of that and try to frame the context around what that may or may not do, although I have to confess I haven't read it in detail.

MR. GLASS: Yes, we've been trying to follow some of the legislation. First there was something called the MEFRA, Medicare Enforcement Fairness Regulation Act or something like that. That was around. Then the Ways and Means Committee had theirs, which was -- did it have a name, or just 2786? They had their version of a regulatory burden bill.

MS. NEWPORT: I guess it would be helpful --

MR. GLASS: And then Commerce has now become the RACER bill. A lot of those tend to deal with the appeals process and some -- at one point there was things about could they use extrapolation to go from a sample of 30 claims to a universe of claims. We know that those things are around, and that's why we're trying to go to some of the root causes of complexity, rather than to address each of those things they happen.

MS. NEWPORT: Contextually, I'll go and revisit it now myself. But the other issue, and I hope that we can put it in the text, in alignment with this first recommendation, is that on the policy interpretation side, for health plans, when we have people go for urgent out-of-area care or to a non-participating provider, we do pay them on a fee-for-service basis, emergency care as well. It is very, very difficult for health plans to pierce the interpretation network, if you will, for the fiscal intermediaries and others that determine payment and policy and make coverage decisions.

It's been something that CMS has been somewhat reluctant, because it's in another part of the house if you will, allow us access to. So it's very difficult to get this, and there's

extreme variability across the country in some areas. Sometimes it's very consistent.

So if nothing else, in reference in the text, talk about the plans that other payers have. And the line is you're not a provider. Well, indeed we are a provider in some context. So I think that would be helpful to acknowledge that we can only pay properly if we have access to the data that way.

MR. HACKBARTH: Jack, before you take it, it would be helpful if we could have for the commissioners very brief summaries, if you will, of some of the major ideas in the bills on the Hill. I'm not talking about all of the gory detail. I'm just looking for something that will help stimulate our thinking about what the possibilities are. So brief and high level.

MR. GLASS: We can send you that by e-mail.

MR. HACKBARTH: Janet was just asking whether we're going through draft recommendation by draft recommendation. I don't think that's necessary at this point, because it's not like we're trying to prepare for a vote on any one of these recommendations. Again, we're trying to get the major ideas.

DR. ROWE: David, I found this material, clear, well presented. I have a couple of general comments, some of which may expose my lack of familiarity with CMS.

First of all, I do think it's helpful up front to identify that the problem, however you want to state it, has several elements, one of which is regulatory, one of which is the complexity of the system, but one of which is cultural, structural, et cetera in the organization that we're seeking to modify. There are some inefficiencies. Some of it is related to less advanced technology and inadequate capital investment, but there are some other inefficiencies and retention of archaic activities. Something that shows these different things.

If I were faced with trying to fix this organization, I would do two things. It may not work and it may not be the right approach. The first is I would wonder why there isn't more discussion about one of the most effective levers that you have in making these changes, and that's money. What is the relationship between the CMS budget and the problem.

There are a lot of people, some here, who write articles saying that CMS is chronically underfunded. If I were a congressman and I thought there was too much of it and it wasn't efficient and there were too many layers of administration and too many regional offices and too many people, the last thing I would want to do is feed it more so it could grow more levels of complexity. And I might say let's feed it less and see what happens.

If you, in fact, yoked feeding it less with you guys give us a list of the things you want to get rid of and we'll get rid of them for you, but you can keep the money. That is, nobody's going to give you a list of things to get rid of if, when you get rid of them you take the money away that supported those activities, or you take all of it away. There might be some "profit share."

Some discussion about the relationship of the budget to the problem, because it's not clear whether we need to feed it more

so it can be more efficient and re-engineered or feed it less so it doesn't grow more complexity and layers upon layers.

MR. HACKBARTH: Jack, Murray just said you're proposing prospective payment for CMS.

DR. ROWE: I just think the documents we create should at least have a paragraph on this. Like one commissioner had the absurd idea that maybe -- but that was laughed off the court.

The second thing that I would do, after I wondered about the relationship of the funding to the problem and the fix, is I would say who should I get to help me with this?

I don't know everybody in this room, but I don't think the person to help us with this is in this room. With all due respect to your background, there are people who do this for a living. There are people who have doctoral degrees in organizational development, re-engineering. This is not the first kind of problem like this. And what expertise does MedPAC have with respect to these kinds of mega issues?

So then what we wind up with is a list of draft recommendations which are kind of ad hoc on here's an idea, everybody thought this was a stupid thing, let's get rid of that. And maybe we have too many regional offices. But my guess would be that if we did all of these things it wouldn't fix the problem.

So I just wonder whether or not somebody else should do it. I know we're not supposed to make recommendations like that, either, but...

MR. HACKBARTH: Our recommendation is, take this back.

DR. ROWE: You sent this to the wrong office. So anyway, those are my thoughts. Thank you.

MR. HACKBARTH: Could I just react to Jack's point? Two reactions, on the last point about other people having more expertise, I certainly think that's true in some aspects of the problem. I really don't think the charge to us, though, was to redesign CMS or do a reorganization where clearly we did not have the expertise.

I think they are looking to us, though, to point in some general directions.

DR. ROWE: One of which could be to hire an outside organization.

MR. HACKBARTH: One key issue you put your finger on at the front end of your comment is the link between flexibility and efficiency, which is what we've been saying to providers for a long time. The problem we have right now, as I see it, is that we've got no flexibility, lots of very specific commandments in terms of how things are done, and then an expectation of efficiency. And you can't have that combination.

It's sort of a basic point and it doesn't take a genius to figure out, but apparently it needs to be emphasized. I think we can make a contribution there, just pounding on the nail some more.

MR. DEBUSK: Jack, maybe we have too many of those kinds of people you're talking about stirring the pot in the present situation.

One of the overlying things that's a major problem, as you all know, we just do not have the information systems to give us the information, even as a commission, to do the things we need to do. Now that's overlying everything.

Underneath, though, I agree with your statement. CMS should move to a standard nationwide system of claims processing. I agree with that 100 percent.

But one of the other things we need to do is certainly reduce the number of fiscal intermediaries that we have. I think we should reduce that to six or 10 or something like that, because right now it's very inadequate. You have a few that do an outstanding job. I think we should look at those people who are doing an outstanding job and see if we can drive the reduction in their direction.

The other thing, last year we rolled out all these prospective payment systems mandated by Congress. We rolled it out there, there was no dollars given to CMS to train the fiscal intermediary, certainly no dollars to train the provider. So what did you get? Total confusion, absolutely we just missed the boat.

When we roll out these programs, we need to fund the educational piece of these programs. That is really missing in the present system, in my estimation.

Another thing we need to do is reduce the number of levels to interpret policy. By the time it gets to the provider, how do they know what to do? You pass through two or three or four levels of decisionmaking at the various levels. Some of those levels need to be wiped out so we've got a more straight access to what the real rules and regulations are.

DR. WAKEFIELD: I actually like this set of recommendations that you put forward. By anyone's definition, this will not be a panacea and address all problems under all circumstances. But I think in general what you put forward is a good place to start. Even by virtue of raising some of these issues -- like in the second recommendation, gee if you pay attention to the guidance that you get from people who represent Medicare, you still are subject to civil penalties if there's an inconsistency between what you were told and what the law really is.

I think, in some respects, these recommendations, by stating them are going to illuminate how ridiculous some of the stuff is. That's a good example. Because it's likely that while the providers may be aware of this, not all policymakers are. And so even naming some of these problems, I think, is a positive thing.

So that's just a general reaction. I'm sure there could be a different set, or maybe a more comprehensive set, but I just think in general, for different reasons, it's a good point of departure.

Two comments, specific comments. One on the first recommendation, David. Would you tell me, it seems to me in the abstract this makes perfect sense, a standard nationwide claims processing system. But in my interest in not overlooking anything, was there any significant feedback that you can recall from any of the groups or individuals, providers or others, that you might have spoken with that would have raised any flags about

that that didn't come through in the text? Anything in particular? Or was it pretty much consensus on that one? Because as I said, I think in the abstract it makes sense. I want to make sure I'm not overlooking anything.

And then secondly, and my last comment, on the recommendation that talks about CMS testing regulations before putting them into effect, that's another no-brainer, one would think at some level. But I guess I'd ask is there a reason to put, at least in the accompanying text of this, that we should include that when those regulations are tested, they should include a focus on any group that might experience a differential impact?

So for example, maybe it's a broad regulation but it may impact academic health centers, or have the potential to in a slightly different way, whatever the new regulation is. Or it might impact small rural hospitals under certain circumstances in a particular way.

So could they put a little bit of a filter on it when they think about that testing that would allow us to look at any kind of differential impact, at least in a broad sense, higher compliance costs or whatever for a particular subcategory? If that could be added in the text, that might be useful.

MR. GLASS: We can certainly put that in the text.

DR. WAKEFIELD: That's all I have, and if you'll comment on the first.

MR. GLASS: The first one, I think the most controversial part of this might be the local Medicare review policy, getting rid of local Medicare review policy may be the most controversial thing. Because some people feel that -- well, I'm not sure what they feel. They either feel that there really are local circumstances that make people there or maybe the facilities there different, and therefore different things should be covered.

I don't follow the logic of it really, but there certainly is a group of people who feel that that's very important and if they can get a device approved perhaps in one place and in one region, then that will be a better argument for getting it approved in others.

I don't quite follow the logic because if you have evidence-based medicine and you know that something is a good idea, then I think it would be a good idea nationally. In the absence of that, I don't understand how you know it's a good idea.

I would say that's probably the most controversial thing.

DR. NEWHOUSE: Two general reactions. One is, I thought we should attempt to frame some recommendations that would be directed at simplifying life for beneficiaries. All of our recommendations here are directed to providers. And while they all seem reasonable, at least at first blush, to me, we have quite in the draft text that talks about beneficiaries but then nothing in the recommendations.

I was talking about this with Glenn beforehand, who recalled for me the Barbara Cooper-Bruce Vladek document that we've been sent that we both think has some potential leads for recommendations.

The second general reaction on the recommendations that talk about the nationwide system both for standards and for enforcement, several recommendations. I wondered if it would be useful to reflect what has been learned with respect to the IRS. The IRS also has a very complex set of regs to enforce. I know the literature, they don't get enforced uniformly across the country. Even though the system that is here might, in some respects, you're trying to move it toward where the IRS is.

There's also, I think, some enforcement differences and potential multiple -- I don't know enough about the IRS to go much further down that road, but it struck me that you might take a look at what lessons, either positive or negative, the experience with the IRS has to offer here.

MR. GLASS: I don't know how popular we'd be if we said we want to be more like the IRS.

DR. NEWHOUSE: No, but all the more reason to -- in ways of being realistic about what this will accomplish. I mean, I think these suggestions, as I say, make sense to me but they won't be a panacea.

MR. GLASS: No, they won't. And the IRS has the same problem of whether if you get guidance from someone over the telephone --

DR. NEWHOUSE: So how do they deal with this then?

MR. GLASS: There are some certainly similar things.

DR. REISCHAUER: I know a little more, but not probably enough to be quoted outside of this room. When you get an answer on the telephone, it can drive your behavior but it's worth nothing beyond that. The IRS issues letter rulings when you send in and ask a question. The letter ruling officially only applies to your situation but, in fact the tax courts use it as precedent and then there are special tax courts and findings in them.

So I think it really is a level of treatment of these issues that is fundamentally different from the way Medicare is.

DR. ROWE: But in the area of health care there are also precedents. I believe a law was recently passed in Texas, but I don't think it was signed by the government, that had a provision in it that if you were a provider and you were on the phone with a health plan representative and you said I'm going to do an operation on Mrs. O'Brien for such and such, and the health plan representative said fine, that's approved over the phone.

And on January 31st Mrs. O'Brien stopped being a member of your health plan because her employer switched and the operation was done on March 1st, the health plan still had to pay, even though that person wasn't even a member anymore. Because there had been an indication verbally that the health plan would pay. That's a law somewhere in the United States of America, I believe.

So with respect to -- forgetting the IRS, you can go to other elements of the health care enterprise and see examples of relationships between providers and the payer which might inform your decisions with respect to this.

Alan may know more about this. I don't know if this is accurate from your point of view, Alan.

DR. ROSS: Just a couple of points to react to Joe. I

guess, first of all, it's telling that the Joint Committee on Taxation put out a 1,500 page three volume document on simplification in the tax world, so it's not easy.

But on your point about doing something with respect to beneficiaries, I guess a couple of things. One, we actually made a number of efforts to reach out and find some of the issues there. Whether it reflects the fact that there's not a lot of money attached on that side, we did not get an overwhelming amount of feedback from people.

One of the pieces of low-hanging fruit that we did find was on Medicare secondary payer provisions, which had people filling out a form with every encounter. That's actually already being addressed.

The other, I think, major source of complexity from the beneficiary perspective is inside the benefit package and I think perhaps a good place to deal with that is in the June report that we'll be talking about later this morning.

DR. NEWHOUSE: Then I think we should point toward that. I would have said also a source of complexity in the program is the probably lack of a stop-loss provision in both Parts A and B that drives people into supplementary insurance, which creates all kinds of interface issues.

MS. RAPHAEL: But I think that's reflective of the past, that the beneficiary side is not organized in a way that they can make known some of the issues.

DR. ROSS: But even in our attempts to work with organized beneficiaries we did not get a lot of input.

DR. NEWHOUSE: But there is stuff in the text that points toward recommendations. They just didn't seem to surface in chapter five.

DR. ROSS: Do you want them to?

DR. WAKEFIELD: Could I comment on this point? David, it was really helpful to me that you included the text from the legislative language for this particular study on the front end of this document. Then there's no confusion about what it is Congress is asking us to look at.

Just on Joe's point, it's asking us to look at providers. If this is all there was on this study, it really seems to be very provider focused. I'm sure that doesn't negate adding some beneficiary-related recommendations, but it seems -- at least my reading on this, it's impact on providers.

MR. FEEZOR: Joe had exactly what I was observing and I, too, had picked up that, in fact, Congress had asked for it from the provider perspective.

I'd just like to note it might be worth reflecting that I think the fact that Congress views the program in sort of a constituency silo mindset may, in fact, contribute to some of the complexity. And I think to really look at the kind of overall simplification and improvement that Jack was talking about -- and I do think politically there may be some opportunities to look at it in a much larger perspective -- I think backing out of that specific constituency impact group mindset on a broader perspective -- and I do think, Glenn, your comments about the forthcoming June report may provide an opportunity.

So it may be helpful, I would think, in the context of saying this simplification effort, or it may be very helpful to be undertaken after or subsequent to a revisiting of the program is going to be redesigned at some point, in terms of its benefit structure. Because I think that would change the game rather substantially.

MR. HACKBARTH: Just for the record, the mandate does refer to patients as well as providers. The summary--

DR. ROSS: The next page, the top. The top of three.

MR. HACKBARTH: The actual statutory language is there. What I'd like to do is go back to our queue. We've got a bunch of people who have been patiently waiting here and I want to get to them.

MR. SMITH: Let me try to be brief. David, I found this very helpful and learned a lot from reading it.

A couple of observations. Actually, Jack provoked the first one. I think it's important to remember that the complexity of this system shouldn't be analogized to sedimentary rock. It didn't just accrete over time. It has very deep constituency roots.

The complexity here has a political dimension and Allen just referred to it, in part. But I think as we think about what it is sensible to recommend, and I mean sensible in an efficiency sense, we need to be mindful of the political context in which the complexity arose and some of the reasons that it is unlikely to go away.

In that context, I think we should try to distinguish between where we can reduce complexity with technology and better information systems and better processing where the political obstacles will not be as serious, and where we think we want to try to reduce complexity by going after someone who, in turn, has political weight and political muscle.

I think there's an important difference. I thought the weight of the recommendations didn't focus enough on some of the technological and information system opportunities where I think the resistance will be less.

Second, I was struck and I think a little troubled by the discussion on front end rigor, back end rigor, again in part for political reasons. Back end rigor comes because that is always low-hanging fruit for politicians. Fraud and abuse, a corrupt provider. It doesn't make any difference whether it's .1 of 1 percent of all providers, it's an irresistible target and no sensible bureaucrat is going to set themselves up for that kind of attack at the back end.

Unless we had a profound, and extremely unlikely, change in the political culture, I don't think we can expect bureaucrats to reduce their back end rigor and make themselves low-hanging fruit on the fraud and abuse.

I wish you were right, that this tradeoff were possible, but I really don't think it is. The tolerance of the bureaucratic apparatus for the political attacks that come at the back end is very low and it's hard to imagine it could be otherwise.

I think some of the same political constraints apply to the flexibility issue but I think that's more promising.

Lastly, Jack, on your do you feed the beast or starve the beast, I think it's the wrong question. If you don't change what the beast has to do and you give it more money, you get more of what you don't want. But money is not the problem. The problem is what you're telling the apparatus it has to do.

I think to think about it is could you fix it by starving it? The answer is probably no. You would just do everything that you now do badly even more badly because you had fewer resources.

DR. ROWE: I think, if I could respond, I accept that, David, but I'm not ready to reject the notion that linking some of the changes that we want the organization to do with financial incentives, one way or the other, so that could in fact benefit from improving its efficiency, by having more internal resources to use for other things, or something like that might not facilitate some of these behaviors.

These are, after all, even though they're CMS, they're still human beings. And they do respond to the same incentives that everybody else does. In fact, maybe moreso because they've never been exposed to these incentives. That's really what I mean.

MR. SMITH: Fair enough. But I think that is a different question than the one you initially posed which is, does it make sense to try to make it harder for the apparatus to introduce complexity by giving the apparatus less money? I think that's the wrong question. The complexity is introduced by and large externally, unless money simply makes it even more clotted and clogged up.

MR. MULLER: My comments follow somewhat on David's. I think a lot of the complexity is, in fact, introduced by the pace of all the changes that are introduced. For better or for worse, providers figure out with rules that are 10 or 20 years old, how to live with them and adjust them and so forth. And when many come along, they may not like those rules but they figure out how to deal with them.

It strikes me that the pace of change is not going to slow down at all because Medicare is just inherently a political process. Some of the stakeholders wants things changed and those things will continue to change.

From both the point of view of CMS and from providers, in some ways however, the regulations, the laws that come forth are seen seemingly as cost-free to them. The CMS budget, as various people pointed out, doesn't get increased when BBA comes along and so forth. A number of the administrators wrote last year in Health Affairs about underfunding. That's been discussed here.

And providers really also don't have their budgets increased when these various rules come along.

So one of the suggestions I would make that we consider is that as new legislation is passed that both CMS and affected people, whether that be providers or intermediaries -- and it's not clear to me how one relates this to beneficiaries -- somehow get some adjustment as a result of this, or a CMS budget or a provider budget gets adjusted to take into account. Otherwise the rules that come along, in a sense, are seen as cost-free and obviously it brings the administrative budget of providers to

what I understand to be the highest of the G-7 countries in the health program as a percentage.

Obviously we have a lot of data indicating that the CMS budget is defined as one of the lowest vis-a-vis the expenditures on the health plan.

But I would like to ask the staff whether the right form for this is to consider some kind of recommendation that the costs of regulations be put into the CMS budget and into Medicare's cost basis in some kind of appropriate way. Because otherwise these rules are just going to keep coming forth. And I do think that a lot of complexity, in fact, comes from the constant changing of this.

Understanding, at the same time, that there's a reason for this changing, as David and other people have articulated. People want to change the program because the stakeholders want to see changes. I don't think that's going away. I think we need to have some accommodation, however, for what kind of havoc that wreaks in the system when these things are changed constantly.

DR. LOOP: I don't think this commission has the ability to debride all these regulations, but we do have one resource and that's common sense, which I think are applied in these recommendations.

There's one worry that I have, and that's the consolidation of some of these fiscal intermediaries or other contractors. I'm not sure we wouldn't be just creating fewer and larger bureaucracies. I think that we have to have uniform and simplified standards and, as many discussants mentioned, fewer decisionmaking layers. Otherwise we're creating very large bureaucracies again.

MR. GLASS: We left open what would the efficient division of labor be and how many contractors of what sorts you'd want. We don't say how to do that. We just want to get rid of the layers of decisionmaking in there, and the fact that if you have different systems and different rules in different places it complicates the system. I'm not sure we'd be creating --

DR. LOOP: As long as we simplified the new standards that apply to those new contractors.

DR. NELSON: David, I really liked the way that you approached this. I agree with the recommendations. While some of them are structural, a number of them are process. I'm comfortable that those that fall within the structural context are prudent and reasonable and it doesn't bother me that we aren't experts in organizational design.

I also subscribe to your approach to look at the overall tree, but there might be a couple of branches that are worth pruning just because they're so pervasive in causing problems and hassle. I think that it would be well worth referencing the documentation requirements as a major source of confusion and disgruntlement.

If you do that, it seems to me that it would be perfectly appropriate among those process recommendations that you have to make a recommendation that the Secretary would conduct a demonstration of evaluation of management requirements based on

encounter time, or something of that sort, at least to put on the record that we considered some concrete specific steps to deal with one of the biggest problems, which is documentation and coding complexity confusion.

The need for applying diagnosis codes to all laboratory tests drive people nuts. The way carriers deal with that is so uneven and confusing that it just -- and that's such a big problem that I think we can deal with this in the general context as you do. But we can still identify a couple of very specific areas that are such a big source of consternation.

The second example that I think you should consider referencing, and perhaps have a recommendation, deals with the difficulty that we encounter with extrapolation from a small sample to a large universe. That drives people crazy. A person makes a simple coding area and all of a sudden they get a payback bill for hundreds of thousands of dollars in some instances.

Perhaps one of our recommendations could be to consider restriction on extrapolation if it's the first time that the error is caught. It doesn't seem to me that that is getting too specific. It seems to me that people who read our report are going to fault us if we don't include some things that everyone agrees is causing so much problem out there.

So I'd suggest considering that.

MR. GLASS: We thought about how to look at some of these specific ones which are well known. I think you can add to that list the Medicare secondary payer question and the ABN, advance beneficiary notice. On site visits, these things just kept coming up. The E&M documentation is another biggie. These things kept coming up.

I think in some cases we used them as examples, but we refrained from having a section on each of those because a lot of these things are already being addressed either in CMS or in Congress. We didn't think we had much to add to that. But do you want to mention them? I don't know.

DR. NELSON: Why don't you humor me and include them, and when we consider our recommendations if you all want to argue to delete them, it's okay with me.

MR. HACKBARTH: To me the approach of having the recommendations broader gauge, but then when there are some particularly poignant examples of problems having them mentioned in the text is a good approach. Do you feel comfortable with that, Alan? It sounded to me like your request was that, for some of the most flagrant examples, let's make sure that they're mentioned in the text as opposed to recommendations to the Secretary to use a different statistical approach.

DR. NELSON: I think the important thing is to have it mentioned in the text. But it may be that acknowledging in the text the problem logically leads to a relatively simple next step, which is to investigate some way to handle it. I don't want to burden this with a whole bunch of those kinds of things, but if there are a couple that everybody agrees is a major heartburn or headache cause, we ought not to miss the opportunity to make a recommendation to do something about it.

DR. ROSS: Can I just interject one logistical issue for us

on this? A lot of these things are being dealt with in legislation that is currently moving, may or may not make it out of the committee or through one chamber by the next time the commission meets. It's probably better if we're not making recommendations that by the time this hits the streets have already been enacted and put into law. Whereas, if we illustrate I think specific issues, we can use fairly strong words to describe them, but keep them under the rubric of the general problem and then the specific application of it.

That may address what you want but without putting us in a position of having recommended something that's already been fixed before we even get the report out.

DR. ROWE: I see the problem is that we all have our favorite list of annoying, incredible policies that CMS has, as well as Aetna has and every other large organization. I see, however, like this example that Alan suggests, this is a policy. CMS could be the most efficient non-regulated organized entity in the world and it might still have a policy that if they catch this kind of an error they extrapolate to that provider's entire patient population and send the guy a bill. It's unrelated to regulatory burden, it's unrelated to complexity. It's a policy of how to deal with this kind of activity.

So I see it as a different kind of thing than this chapter is supposed to deal with. It's a fairness kind of issue.

So we don't want to have too many different kinds of things on our list of favorite things we want to fix because the risk is that they'll fix all these favorite things but not change the entire system, which is really I think the overall question.

I'm not against including some of these things but we should candle each of them up to say is this really a regulatory complexity problem.

MR. HACKBARTH: Let me just do a process check here for a second. It's almost 10:10, so we're already over time on this. I think this is a very important topic and, in addition to that, we don't have a whole lot of time left on it. We certainly don't have a lot of meeting time left to get this work done.

So I do want to go for another 10 minutes or so, but one thing that we need to do before we wrap this up is I'd like to go back through the individual recommendations that David presented. Not your discussion, but I just want people to say raise your hand if a particular recommendation proposes a serious problem for you and you would strenuously object to it.

You will have another cut at this later on, so if you don't object that is not tantamount to a yet vote. But we're just trying to provide some direction for the staff in a very short period of time. So I've got two people left on the list to comment, Carol, who's not had any chance yet; and then Joe. But please let's keep it brief so we can get our work done. Thank you.

MS. RAPHAEL: I thought that you did a very good job in terms of organizing the material and I really appreciated the fact that we didn't focus on 30,000 pages of regulations but try to look at the sources of complexity and what we can do. I do like the way David posited it, which is where can we get

something done rather than run into a lot of political barriers.

I think that you've addressed the issue of how do we alleviate the multiple layers and try to achieve some standardization. I think you need to emphasize more that in the federal system the notion of having some kind of local input really is not relevant in the way this program is structured because there is value to having local input and involvement, but we never got that in this program because all of these regional groups or carriers really are not locally-based and don't give you whatever is you value in the system that involves people at the local level.

I think in whatever you create, I think we have to be mindful of the fact that Medicare is the purchasing organization and enforcement regulatory organization. As a purchasing organization it has to decide what it will pay for, what it will pay, and then how to make sure that it gets what it pays for. I think that's Medicare's obligation as a central entity. Whoever this group of entities are that end up being the contractors should be responsible for paying, not for making those kind of critical decisions that I think have to be made by the central body.

I also think you dealt with the issue of how do you increase certainty and predictability in a program now that has had a very high quotient of unpredictability.

What I still feel is somehow missing is the hard part of this, which is how do you deal with the fact that we have rapid change? We have to find some new mechanisms to make more rapid decisionmaking while you still adhere to a political process that has to give voice to many constituencies?

I think that is a really critical issue for this organization. How do we garner more political support for this particular organization and reduce expectations? I don't know what a recommendation might be in that realm, but I feel it's an important realm.

I was thinking of other organizations, the way Joe was of the IRS. There is an organization in New York that is in charge of foster children and child abuse. It's the most abused organization I've ever seen in the public sector because it was in the newspaper every week because it was impossible not to have some instance of child abuse or neglect, and it was always the poster child for a completely ineffective organization.

That has been completely turned around and that organization has become the most effective. You know the innovations in government awards, it gets the award for being innovative. There's just less expectation, more of an understanding, that this entity cannot root out and prevent every instance of child abuse and neglect or every bad thing that happens. There's just much more of a sense of support from the political process, as well as from the citizenry.

I think that is an issue that somehow you need to tackle in our recommendations because I think this will be important in the decades ahead.

DR. NEWHOUSE: I know we're trying to stay at the 30,000-foot level, but there is a technical fix for Alan's extrapolation

problem that if we're going to mention it in the text we should mention it. Basically the statistics of say predicting a baseball player's final batting average when you only observe the average after 10 at bats is not the average after 10 at bats. It's some weighted average of the average after 10 at bats and everybody's average. And the weight on the number of at bats keeps going up as the number of at bats get higher.

That's all well developed in statistics. So the notion of extrapolating from a very small sample can be dealt with.

The other thing, Alan also mentioned linking diagnosis and the text. The only thing that concerns me, we need to make sure we're not tripping over ourselves when we get to process measures of quality and quality measurement on that front.

DR. NELSON: No, I wasn't calling to eliminate that. I was saying it's very confusing the way it's currently required.

MR. HACKBARTH: David, would you walk us through one by one? Again, what I want from people here is a show of hands. Raise your hand if this one causes you significant problem. If in fact there is one that causes you significant problem, rather than have a prolonged discussion of that now, what I'd ask is that you let the staff know, either David or Murray -- I don't know how you want to handle that, Murray -- by e-mail or some means, here's why that one really causes me heartburn.

MS. NEWPORT: We'll see this again in November?

MR. HACKBARTH: Yes. Let me underline that point. This is not tantamount to a vote on these. You will have a chance to look at them all again. And if you don't object today you can object in November. We're just trying to get our bearings here. David?

MR. GLASS: Again, this is to move to a standard nationwide system and eliminate some of the problems caused by having multiple automated systems and multiple systems of people deciding what is policy.

MR. HACKBARTH: I would like to avoid discussion. So if I don't see any hands, it seems to me that people think that something like this would be okay. If you have an objection raise your hand.

Seeing none, let's move on to number two.

MR. GLASS: This recommendation follows from the first one. If you have a nationwide standard system that people can understand, that can be clearly described and people will then understand the answers to, we think that this would follow and this would relieve a lot of the burden of apprehension and uncertainty from providers.

DR. ROWE: I don't think this helps at all because it's ambiguous what official guidance is and that's really the entire question, whether or not a phone conversation constitutes official guidance is going to be the argument, so we need to be more clear on that.

MR. GLASS: Could we put that in the text, we could have some kind of discussion would constitute official guidance, Jack?

DR. ROWE: Yes, sure.

MR. HACKBARTH: Good point. Number three?

MR. GLASS: This one was to the question of, if we then

reorganized the claims processing and all those related kind of contractor entities, could we then rethink the role of the regional offices? Frankly, this is because a lot of people have some questions about what is their role and are they fulfilling it helpfully? So this kind of gets to that.

MR. HACKBARTH: Objections? Number four?

MR. GLASS: This was one of the balance questions. I think the most obvious example here is in the DME world. Clearly, that just made so much sense to be a little more discriminating about what providers were allowed in. We think that kind of principle could be extended.

MR. SMITH: It's not heartburn [inaudible].

MR. HACKBARTH: Number five?

MR. GLASS: Again, a lot of this has come about as a result I think of how funding and that sort of thing was given to the program to do this function of enforcement, and not just to the Medicare program but to others, out of HIPAA and that sort of thing. Different pots of money. Jack, you were talking about if you hand out the money differently you get different results. This is a result of how the money was handed out, and it's not clear that it's the most rational way. I think providers feel that they're being subject to multiple audits and enforcement activities and there should be a better way of doing it.

DR. ROWE: But aren't these enforcement activities from the inspector general of HHS?

MR. GLASS: They're both. That's the complaint.

MR. FEEZOR: Is that as a result of congressional direction, as opposed to --

MS. NEWPORT: To some extent it is.

MR. FEEZOR: Then make that observation. Tactfully, but make the observation.

MR. HACKBARTH: Number six?

MS. NEWPORT: I have a problem with this one. It's not the idea of testing, I want that clear. It's how you establish the process for measuring compliance. I think that's an important distinction.

MS. RAPHAEL: I don't understand what you mean.

MS. NEWPORT: The issues are, in complex organizations like health plans, is having a full audit protocol available beforehand and understanding the rules and regulations that then are the root of those protocols. Part of the issue that comes in in measuring this is not testing that so much, is how you determine the base regulations and then establish the upfront disclosure that everyone wants or reliance on interpretation that you get from CMS is that this is what that means.

And I think that I have a problem with the testing idea. I would like to be a little more sophisticated about what we offer up as rules of engagement, if you will, on this on how you develop the regs as well as what happens when you enforce it.

It's kind of a conglomeration of maybe the last three recommendations. The same idea, it's just that testing sometimes is impossible given the timelines Congress imposes on things.

MR. GLASS: Right. I thought that's why we suggested the reasonable timelines to go with the testing.

MS. NEWPORT: I will share this with you.

MR. GLASS: You can explain it, because I don't quite understand it.

MR. HACKBARTH: We're on number seven?

MR. GLASS: I thought this was relatively common sense.

DR. ROWE: Instead of developing a mechanism, it sounds like you're going to open a new office and staff it. Why can't we just say CMS should eliminate regulations.

MR. GLASS: We could say that.

MR. HACKBARTH: Number eight?

MR. GLASS: This would include a lot of things behind it, but I guess the general tenor, I hope, is reasonable.

MR. HACKBARTH: Thank you, David.

DR. ROWE: Before we discuss this next, can we get [inaudible].

MR. GLASS: Yes.

MR. HACKBARTH: Thank you, David. This is a daunting, daunting task, both in its scale, but also for the reason that David and some other people identified. This is a problem because there are people that have deep attachments to some of these issues and their responses to problems of various sorts. The politics are very, very difficult.

The way I look at the role of the Commission is that we are part of the political process. We are not aside from it. We were asked to do this as part of the process of trying to build a consensus about change. Whether we will, in fact, succeed in helping that process or not, I don't know. But it's our role in this dance of legislation, so we'll do the best we can.